



FH
[REDACTED]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

HMO/151882

PRELIMINARY RECITALS

Pursuant to a petition filed September 03, 2013, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by Community Connect Health Plan and the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on October 15, 2013, at Kenosha, Wisconsin.

NOTE: Lucy Miller, a nurse consultant from the Department of Health Services (DHS) called after the hearing, to reiterate information provided by Melody Suthers in Exhibit 2, that it is DHS's position that Petitioner is not eligible to receive services from Dr. Laurence Gibson.

ADDITIONAL NOTE: The record was held open to give the parties an opportunity to provide additional documentation. Petitioner submitted a letter, a packet of correspondence from DHS/Community Connect Health Plan, and Medical Records from Lake County Surgeons. The documents have been marked Exhibits 3, 4 and 5, respectively and entered into the record. Community Connect Health Plan submitted the curriculum vitae of Dr. Thomas Chua. It has been marked as Exhibit 6 and entered into the record. At my request, Community Connect Health Plan also submitted a link to a copy of their Member Handbook:

<http://www.communityconnecthealthplan.com/docs/791304=399931%20WI%20Member%20Handbook%2012%202011.pdf>

The issue for determination is whether Community Connect correctly denied Petitioner's request for services from an out-of-network provider.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street
Madison, Wisconsin 53703

By: Dr. Tina Mason, Medical Director
Community Connect Health Plan/WellPoint Medicaid
N17 W24340 Riverwood Dr.
Waukesha, WI 53188

ADMINISTRATIVE LAW JUDGE:
Mayumi M. Ishii
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [REDACTED]) is a resident of Kenosha County.
2. Petitioner receives Badger Care+ benefits through Community Connect Health Plan, a Health Maintenance Organization (HMO).
3. In November 2008, Petitioner underwent a Laparoscopic adjustable gastric band placement surgery. Dr. Laurence Gibson performed the surgery. (Exhibit 5, pg. 7; testimony of Petitioner)
4. On July 15, 2013, Dr. Gibson submitted a request for prior authorization for an office visit and lap band adjustment. (Exhibit 5, pg. 5)
5. Patients who receive gastric bands require life-long monitoring and periodic adjustments to the lap band, because over time the bands may become too tight and overly restrict the passage of food and liquid or they can become too loose, which prevents the desired weight loss. (Testimony of Dr. Gibson)
6. Petitioner requires such monitoring. (Testimony of Dr. Gibson; Testimony of Dr. Mason) Since her surgery in 2008, Petitioner's weight has fluctuated significantly between a low of 171.8 pounds 2010 and a high of 215 pounds. Although, within the last year, Petitioner's weight has stagnated between 198 pounds and 210 pounds. (Exhibit 5)
7. On August 5, 2013, Community Connect Health Plan (Community Connect), sent Petitioner a notice indicating that her request for a gastric band adjustment was being denied as not medically necessary. (Exhibit 2 – Attachment 3)
8. On August 22, 2013, Community Connect Health Plan (Community Connect) sent Petitioner a notice indicating that in response to a grievance that she filed, it was denying her request for a lap band adjustment. (Exhibit 4, pg. 2)
9. On September 1, 2013, Petitioner filed a request for fair hearing that was received by the Department of Administration, Division of Hearings and Appeals.
10. On September 3, 2013, Petitioner filed a request for a continuity of care exemption with the Department of Health Services (DHS). (Exhibit 4, pg. 6)
11. On September 9, 2003, DHS sent Petitioner a notice indicating that her request for an exemption was denied because she is not newly enrolled with her HMO. (Exhibit 4, pg. 10)

DISCUSSION

Given that Petitioner's appeal predates her application for a continuity of care exemption, it is presumed that her dispute is solely with Community Connects denial of services by Dr. Gibson. Although, even if the denied continuity of care exemption were an issue, it would be found that DHS properly denied the request since per Under the discretion allowed by *Wis. Stat.*, §49.45(9), the Department of Health Services (DHS) requires MA (Medical Assistance) recipients to participate in HMOs. *Wis. Admin. Code*, §DHS 104.05(2)(a). MA recipients enrolled in HMOs must receive medical services from the HMOs' providers, except for referrals or emergencies. *Wis. Admin. Code*, §DHS 104.05(3).

The criteria for approval by a managed care program contracted with the DHS are the same as the general MA criteria. See *Wis. Admin. Code*, §DHS 104.05(3) which states that HMO enrollees shall obtain services "paid for by MA" from the HMO's providers. The department must contract with the HMO concerning the specifics of the plan and coverage. *Wis. Admin. Code*, § DHS 104.05(1).

If the enrollee disagrees with any aspect of service delivery provided or arranged by the HMO, the recipient may file a grievance with DHS or appeal to the Division of Hearings and Appeals.

Just as with regular MA, when the department denies a grievance from an HMO recipient, the recipient can appeal the DHS's denial within 45 days. *Wis. Stat.*, §49.45(5), *Wis. Admin. Code*, § DHS 104.01(5)(a)3.

Physician services are generally covered by Medicaid, although “all medical, surgical, or psychiatric services aimed specifically at weight control or reduction, and procedures to reverse the result of these services” require prior authorization. *Wis. Admin. Code* §DHS 107.06(2)(c) *Physician Services; Services Requiring Prior Authorization*

When determining whether to approve any service, the HMO, as with the Division of Health Care Access and Accountability (DHCAA), must consider the generic prior authorization review criteria listed at *Wis. Admin. Code*, §DHS §107.02(3)(e):

(e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:

1. The medical necessity of the service;
2. The appropriateness of the service;
3. The cost of the service;
4. The frequency of furnishing the service;
5. The quality and timeliness of the service;
6. The extent to which less expensive alternative services are available;
- 7. The effective and appropriate use of available services;**
8. The misutilization practices of providers and recipients;
9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;
10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

Emphasis added.

“Medically necessary” means a medical assistance service under ch. DHS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Wis. Admin. Code, §DHS 101.03(96m)

For any prior authorization request to be approved, the Medicaid recipient must show that the requested service satisfies the generic prior authorization criteria listed above. At their core, those criteria include the requirement that the service be medically necessary. *Id.*

The following facts are undisputed:

- 1) It is medically necessary for Petitioner to have regular follow up and periodic adjustments to her gastric bands.
- 2) DHS/an HMO previously allowed Dr. Gibson to perform Petitioner's laparoscopic gastric band placement surgery and it allowed Dr. Gibson to perform subsequent follow-up care.
- 3) Dr. Gibson is an out of state physician located in Gurnee, Illinois.
- 4) Dr. Gibson is a certified Medicaid provider.
- 5) Dr. Gibson is not a network provider for Community Connect Health Plan.
- 6) Dr. Chua is the one network provider for Community Connect Health Plan that treats gastric lap band patients.
- 7) Surgeons who perform gastric band placement surgery are not common.

In the case at hand, Petitioner seeks approval for Dr. Gibson to perform a lap band adjustment. According to Dr. Tina Mason, Community Connect does not dispute the medical necessity for regular follow-up care and periodic adjustments to the band. However, Community Connect asserts that there is no medical necessity for Dr. Gibson to perform the continuing follow-up care and adjustments. Community Connect asserts that Petitioner must first see Dr. Thomas Chua, who is a network provider.

Petitioner argues that only Dr. Gibson can perform adjustments to her lap band, because the port accessibility to her band is tricky. However, there is nothing in the medical documentation provided by Dr. Gibson, stating that Petitioner's lap band placement was particularly strange or unique, such that no other surgeon could make the adjustments. I note that at the hearing, Petitioner did not elicit testimony from Dr. Gibson to support her claim.

Petitioner also asserts that she called Dr. Chua's office and was told that he typically did not treat patients whose lap bands were placed by other surgeons, but Dr. Chua did not testify at the hearing and Petitioner did not provide any documentation from Dr. Chua's office to support her contention.

Petitioner also argues that she should not be forced to see Dr. Chua, because his office is located in Milwaukee, which is too far away from Kenosha, where Petitioner lives and works. Per Mapquest (<http://www.mapquest.com>) Dr. Chua's office is approximately 37 miles away from Petitioner's home, where as Dr. Gibson's office in Gurney is located approximately 17 miles from Petitioner's home. Petitioner asserts that she would not be able to take the required time off of work to keep all the necessary appointments.

Petitioner's concerns regarding the time it would take to see Dr. Chua on a regular basis is understandable. However, per *Wis. Admin. Code, §DHS 101.03(96m)*, the fact that the desired treatment is more convenient for the patient, does not make it medically necessary.

Under *Wis. Admin. Code §DHS 107.27(3)(a)*, HMOs must, "Allow each enrolled recipient to choose a health professional in the organization to the extent possible and appropriate." *Emphasis added* *Wis. Admin. Code §DHS 104.05(3)* also states that, "enrollees in an HMO or PHP shall obtain services paid for by MA from that

organization's providers, except for referrals or emergencies. Recipients who obtain services in violation of this section shall pay for these services.” In other words, the administrative code does not require the HMO to allow members to choose physicians outside their network, if an appropriate in-network provider is available. Because of this, Wis. Admin. Code §107.27(3)(i) requires HMOs to “Provide that if a recipient who is a member of an HMO or other prepaid plan seeks medical services from a certified provider who is not participating in that plan without a referral from a provider in that plan...the recipient shall be liable for the entire amount charged for the service.”

It should be noted that Wis. Admin. Code §DHS 104.03 states that, “free choice of a provider may be limited by the department if the department contracts for alternate service arrangements which are economical for the MA program and are within state and federal law, and if the recipient is assured of reasonable access to health care of adequate quality.” *See also Wis. Stats. §49.45(9)* In other words, a recipient’s choice of doctors may be limited as long as the recipient will receive adequate (not necessarily the best available) health care.

Dr. Mason testified that an exception to Community Connects requirement that patients must see an in-network provider can be made if there is no physician able to perform the needed service within 50-75 miles of the patient’s home. However, the on-line Member Handbook contains no such information. According to the Member Handbook, Page 18, Community Connect allows patients to see an out-of-network provider when 1) the patient lives in a rural area and there is only one HMO; 2) A network provider refuses to perform the needed service for moral or religious reasons; 3) A network provider thinks the patient needs other services that would put the patient at risk if he/she gets the services separately; or 4) The network provider thinks the patient needs services that would put the patient at risk if he/she cannot get the services in network. This is more consistent with the aforementioned provisions of the administrative code.

Looking at Dr. Chua’s curriculum vitae, it appears that he is an appropriate in-network physician to at least evaluate Petitioner’s case and determine whether it would be safer and more effective for Petitioner to remain with her original surgeon. Indeed, Dr. Chua performed the first Lap-Band System implantation in Wisconsin in 2001 and has since performed over 1230 Lap-Band System Implantations since February 2001. (See Exhibit 6)

Clearly, Petitioner has missed a step in the process. Petitioner testified that she called Dr. Chua’s office, but that she did not make an appointment with him for an evaluation. If Petitioner wishes the HMO to cover services with Dr. Gibson, she must first be evaluated by Dr. Chua, or at least get a statement, in writing, from Dr. Chua stating that he will not do the lap band adjustment because of the potential risk posed to Petitioner. If, indeed, Dr. Chua refuses to perform the lap-band adjustments because he thinks it would be too risky for him to do so, then per the policy stated in Community Connect’s Member Handbook, there would be no one in the network to perform the necessary service, and Petitioner could be allowed to see Dr. Gibson, subject to all prior authorization criteria being met.

Because, Petitioner was not evaluated by an in-network provider and because she did not receive a referral back to Dr. Gibson, by an in-network provider, Community Connect / DHS properly denied Petitioner’s request for services.

CONCLUSIONS OF LAW

Community Connect correctly denied Petitioner’s request for services from an out-of-network provider.

THEREFORE, it is

ORDERED

That the petition is dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

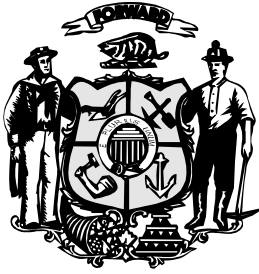
You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 31st day of October, 2013.

\sMayumi M. Ishii
Administrative Law Judge
Division of Hearings and Appeals



State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on October 31, 2013.

Division of Health Care Access And Accountability